

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services Region VIII

FINAL REPORT

1915(b) Managed Care Waiver Review Colorado Medicaid Mental Health Program

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Introduction

Section 1915(b) of the Social Security Act authorizes the Secretary of Health and Human services to waive certain Medicaid statutory requirements of Section 1902(a) in the Social Security Act, for Title XIX. In 1993, the Secretary granted a 1915(b) waiver to Colorado mandatory Medicaid Mental Health Program. The Colorado Medicaid Program is organizationally located in the Department of Health Care Policy and Financing (HCPF) for the State of Colorado. HCPF is the single state agency authorized by the Secretary of Health and Human Services to administer Federal Medicaid funds and implement the Medicaid Mental Health Program through the 1915(b) waiver.

Since the Centers for Medicare and Medicaid Services (CMS) are charged with oversight and monitoring for Colorado's 1915(b) Waiver program, CMS conducted an on-site review of the Medicaid Mental Health Program. CMS wanted to determine program compliance with Federal statute, regulations, contract compliance, and evaluate the implementation of the approved May 2003 mental health Waiver renewal.

The CMS on-site review identified the following findings:

- There has been a lack of oversight and monitoring of the Mental Health Waiver.
- The Mental Health Quality Strategy, required by Federal regulation, is outdated.
- Enrollment Rosters given to the providers are not compliant with Federal regulation.
- Enrollee information requirements are not compliant with Federal Regulations.
- The Mental Health Program provider network needs to be certified to CMS by the State.
- Mental Health Program is not contract compliant regarding mental health services for a person with co-occurring mental illness and developmental disabilities.

Information requirements for the Grievance and Appeal processes are not compliant with Federal regulation.

CMS makes the following general recommendations to the State:

Review and develop in collaboration with the mental health organizations a less burdensome and difficult intake process for the enrollees.

Require the mental health organizations to keep an active number of consumers on their boards, committees and councils.

After completion of the review, CMS determined the following areas will require further evaluation and review:

- Residential Treatment Centers and their role in the Medicaid Mental Health Program.
- Child Placement Agencies (CPA) and their role in Medicaid Mental Health Program.
- Contracts between Counties, Department of Human Services (DHS) and the mental Health organizations that provide Medicaid mental health services.
- Alternatives to Inpatient Hospitalization Initiative.

Overview of Colorado's Medicaid Mental Health Program

The Colorado Medicaid Mental Health Program began in 51 counties in 1995. Three years later, the program had expanded to all counties of the state. Mental health services are provided by eight (8) mental health capitated organizations referred to as Mental Health Assessment and Service Agencies (MHASAs). Each MHASA operates in a specific geographic area with a single MHASA in any given area. They are required to provide all medically and clinically necessary mental health services to all Medicaid recipients who are enrolled in their programs.

The State's contract with the eight (8) MHASAs addresses all areas of the program such as: financial accountability, quality assurance, consumer rights, and coordination with other human service agencies (i.e. child welfare, developmental disability services, substance abuse services, schools, law enforcement agencies, etc.).

The initial waiver allowed the State to implement a mental health program for a two-year period beginning July 1, 1995. Waivers have subsequently been renewed by CMS through May 2005. The State is currently providing Mental Health services through an approved waiver which will expire May 2005.

Initially, the Mental Health Services Division within the Department of Human Services (DHS) was delegated authority by HCPF to administer the Mental Health Program through a written Memorandum of Understanding (MOU). In April 2004 the Colorado Legislature returned the administration and operation authority of the program to HCPF.

All Medicaid eligibles are mandatorially enrolled in a MHASA based on their location of residence. Only the following categories of Medicaid eligibles are excluded from the capitated Mental Health program:

- Qualified Medicare Beneficiary only (QMB),
- Qualified Working Disabled Individuals (QWDI),
- Qualified Individuals (QI 1),
- Special Low Income Medicare Beneficiaries (SLMB),
- Undocumented aliens,
- Refugee program (non-categorical refugee assistance),
- Program of All-inclusive Care for the Elderly (PACE),
- Individuals who are inpatient at the Colorado Mental Health Institute at Pueblo who are found by a criminal court to be Not Guilty by Reason of Insanity (NGRI), Incompetent to Proceed (ITP) or ordered by a criminal court to the Institute for evaluation,
- Individuals between ages 21 and 64 who receive inpatient treatment in the Colorado Mental Health Institute at Pueblo or Fort Logan,

- Individuals who are NGRI and who are in the community on Temporary Physical Removal (TPR) from the Institute and who are eligible for Medicaid and are exempted from the program while they are on TPR,
- Individuals residing in the State Regional Centers, and associated satellite residences for more than 90 days, and
- Individuals that are given exemptions from the capitated program.

Overview of Review Activities

The goal of the CMS review of the Medicaid Mental Health Program was to obtain a general understanding of the Administrative Structure, Operations and Service implementation of the program, to determine State and MHASA compliance with BBA regulations, and compliance with the 1915(b) Medicaid Mental Health Waiver. The scope of the review included on-site visits to the State Medicaid Agency, three Metro MHASAs and one Community Mental Health Clinic in a rural community. An in-depth desk review of documents and reports was also conducted. In addition the intent of the CMS review was to do an overview of the following areas of the State Medicaid Agency; Enrollment and Related Functions, Delivery Systems, Access, and Quality.

On June 14, 2002 CMS published Medicaid managed care final regulations which implemented the provisions of the Balanced Budget Act of 1997 (BBA). Many of the regulations placed new program requirements on the State and MHASAs. During the review CMS specifically evaluated the implementation of the regulations pertaining to information provisions, enrollee protections, quality protocols and grievance and appeals.

The review began at HCPF with an entrance conference March 22, 2004. The entrance was attended by Vivianne Chaumont, Laurel Karabatsos, Antoinette Taranto, Donna Kellow, Diane Dunn, and Joe Keebaugh from HCPF and Cindy Smith, and Di Friedli from CMS.

See <u>Appendix A</u> for a list of the interviews that were conducted as part of the review. Interview questions focused on the Administration of the program, monitoring activities, access to services by beneficiaries, system processes, BBA compliance, and Quality Improvement programs.

In order to gain an overall understanding of the program CMS chose to visit the following three (3) MHASAs: Behavioral Health Care Inc., Access Behavioral Care, Mental Health Center of Boulder County, and a Community Mental Health Center - Centennial, which is part of Northeast Behavioral Health MHASA. It was very informative to visit with the MHASAs and get their perspective on budget cuts and various aspects of the mental health program. They all stated that the budget cuts had encouraged the organization to find more effective treatment modalities to deliver behavioral health services that result in better outcomes and cost savings.

All the organizations provided exceptional hospitality and an overview of their programs, in addition to providing many documents, reports, and charts that CMS had requested. See **Appendix B** for list of documents reviewed.

While on-site at the MHASAs and mental health clinic, CMS reviewed a sample of medical records which were randomly selected prior to the on-site visit. The sample of medical records included records for the following eligibility groups and programs: Foster Children, Residential Treatment Centers, 1931 Medicaid, Baby Care Kinds Care, Adults and Children, and medical records on consumers that had been released from the Institutes of Mental Disease (IMD).

6 2004 Mental Health On-Site An exit conference was held July 21, 2004 with Vivianne Chaumont, Laurel Karabatsos, Antoinette Taranto, Donna Kellow, Annmarie Maynard, Roger Gunter, and John Bartholomew from HCPF with Cindy Smith and Di Friedli from CMS.

Results of the Review

Finding 1

There has been a lack of oversight and monitoring of the Medicaid Mental Health Program by DHS and HCPF. When the program began DHS was delegated authority by HCPF through an MOU to administer and operate the Mental Health Program. However, the MOU was not renewed after 2001. Disagreements began between the two agencies early in 2003. Legislative action was taken in May 2004 to transition the program to HCPF. It was during this time of disagreements and transition that lacked oversight and monitoring of the program by either agency. It was a time of transition from one agency to another. Roles and responsibilities were not entirely clear to those involved, including the MHASAs and Medicaid consumers.

Statute/Regulation/Waiver Site:

The current Mental Health 1915(b) Waiver states that the Mental Health Services Division within the Department of Human Services has authority to administer and operate through a written MOU between HCPF and DHS the Mental Health Program.

Requirements:

- 1. HCPF must submit an amendment to the current waiver, which is to reflect current Administrative Organization and program changes since May 2003. (HCPF is currently in the process of working with CMS and updating the 1915(b) waiver.)
- 2. HCPF must develop a Monitoring Plan for the mental health program, to include timelines for monitoring reports to be submitted to CMS RO.

The Monitoring plan needs to include at a minimum:

- Access to Services,
- Provision of Contracted Services,
- Benefit reductions and the affect on beneficiaries,
- Grievance and Appeal Process and,
- Provider Network Adequacy

HCPF should submit their monitoring plan to CMS RO no later than March 15, 2005. The staff in CMS RO will provide technical assistance as needed.

State's Response: Agree.

- 1. A waiver amendment was submitted to CMS on November 5, 2004 and was approved on January 14, 2005 by CMS.
- 2. The Department will submit a Monitoring Plan to CMS by March 15, 2005.

Federal Response: Look forward to the Monitoring Plan in March.

Finding 2

The Colorado Medicaid Mental Health Quality Strategy is outdated. Much of the current strategy references the 2000 RFP responses by the MHASAs which make it out of compliance with Federal requirements.

The Quality Strategy should also be in line with requirements of the External Quality Review Organization (EQRO), and MHASA contract requirements.

Statute/Regulation/Waiver Site: 42 CFR 438.202- Each State contracting with an MCO or PIHP must have a written strategy for assessing and improving the quality of managed care services offered by all the MCOs and PIHPs. According to Federal regulation 42 CFR 438.202, the State must do the following:

- Obtain the input of recipients and other stake holders in the development of the strategy,
- Make the strategy available for public comment before adopting it in final,
- Ensure that the MCOs, PIHPs, and PAHPs comply with standards established by the State.
- Conduct periodic reviews to evaluate the effectiveness of the strategy, and update the strategy periodically as needed,
- The State must submit to CMS, a copy of the initial strategy, and a copy of the revised strategy whenever significant changes are made, and
- Provide regular reports on the implementation and effectiveness of the strategy.

Requirement:

The State must update the Quality Strategy for the Mental Health Program by March 15, 2005. At the same time HCPF needs to submit to CMS RO a timeline for reviews and results of the Strategy.

State Response: Agree. The Department and CMS RO discussed and agreed that the Quality Strategy and timeline for review and results of the strategy would be submitted to CMS RO by March 31, 2005.

Federal Response: Agree. Look forward to the updated Quality Strategy in March.

Finding 3

The enrollment roster given to the MHASAs does not contain race, ethnicity and primary language spoken for each enrollee, as required by Federal regulation.

Statute/Regulation/Waiver Site: In 42 CFR 438. 204 it states that the State Quality Strategies must include procedures that identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.

Requirement:

The State must submit to CMS a timeline on or before March 15, 2005 of when the regulation will be implemented.

State Response: Agree. The Department will submit a timeline to CMS by March 15, 2005 that describes the project plan to implement the change. Federal Response: Look forward to the timeline in March.

Finding 4

After reviewing the information enrollees in the MHASA receive, it was found that not all of the MHASAs are providing information as required by 42 CFR 438.10.

Statute/Regulation/Waiver Site: 42 CFR 438.10 (f) are the federal information requirements for information that must be provided to all enrollees.

Requirement:

HCPF must ensure that all enrollees in the Mental Health Program are receiving all the information required in the regulations. This must occur before a new contract with the BHOs can be approved by CMS.

HCPF is to submit a report to CMS RO indicating how and where each information requirement in CFR 42 438.10(f) is being met.

In addition HCPF is required to review the information material for format and comprehension. During the review, CMS found most of the information material given to enrollees is not in a format that was easily understood as required by 42 CFR 438.10

State Response: Partially agree. The Department agrees to ensure that all enrollees in the Mental Health Program receive all the information required by 42 C.F.R. 438.10. The Department disagrees that it must review all enrollee information before CMS approves a new BHO contract for the following reasons:

- CMS' audit exit conference was held on July 21, 2004 and the final report was sent to the Department on January 6, 2005.
- The Department sent the new BHO contract to CMS for review and approval on December 20, 2004. The contract was executed January 1, 2005.

Due to the six-month delay in receiving the final audit report for Mental Health Program for the period preceding July 1, 2004, it is no longer reasonable for the Department to complete this recommendation prior to executing new contracts. It is estimated that review of all five BHOs' materials, if done correctly, would take four to six months to complete. Furthermore, the Department has not executed contracts with three of the previous contractors. It does not seem reasonable to review materials from a contractor with which the Department no longer has a contract.

Federal Response: The CMS RO will work with the Department to determine a new date for the BHOs to have all the information requirements up to date but it will be no later than July 1, 2005.

Finding 5

The current Provider Network Adequacy reports provided to HCPF quarterly by the MHASAs are very detailed and provide some valuable information, however, these quarterly reports are not in compliance with regulations at CFR 42 438.206 through CFR 42 438.208. The State is required to provide assurances to CMS that the MHASAs not only have an adequate network but that documentation can demonstrate the MHASA has the capacity to service the expected enrollment in its service area in accordance with State standards for access to care under the regulation. In addition, the State must certify to CMS that the MHASA has complied with the State requirements for availability of services, as set forth in 438.206.

Statute/Regulation/Waiver Site: 42 CFR 438.206 through 438.208

Requirement:

HCPF needs to provide a certification to CMS as required in 42 CFR 438.207(d), that the MHASAs have complied with the States' requirements for availability of services, as set forth in 42 CFR 438.206. In addition, HCPF needs to provide assurances that the MHASAs have an adequate network and the capacity to service the expected enrollment in its service area in accordance with State standards for access to care and that all the regulations in 438.206 through 438.208 are met.

HCPF needs to provide the above certifications and assurances with the next MHASA/Behavioral Health Organization (BHO) contracts.

It is also strongly recommended by CMS that HCPF follow-up with on-site monitoring to the MHASAs to verify and validate the information in their Provider Network Adequacy Reports.

State Response: Agree. During the site audits conducted in the fall of 2004, the Department reviewed the provider network adequacy reports. The Department agrees to:

- 1. Provide CMS with the certification that the MHASAs/BHOs comply with Department requirements for availability of services as set forth in 42 C.F.R. 438.206.
- 2. Assure CMS that the MHASAs/BHOs have an adequate network and the capacity to service the expected enrollment in its service area in accordance with Department standards for access to care and ensure that the requirements in 42 C.F.R. 438.206 through 42 C.F.R. 438.208 are met.
- 3. Conduct on-site monitoring to verify and validate the information in the current BHO provider network adequacy reports.

Federal Response: Look forward to the above results.

Finding 6

Prior to the on-site review, CMS received a complaint that some MHASAs were not providing mental health services to some individuals on the HCBS-DD waiver due to their diagnosis. This occurred due to disagreements between the MHASAs and the HCBS-DD program providers- Community-Centered Boards (CCB). Disagreements occurred determining whether the diagnosis was mental health or behavioral.

In the 2004 contract between the MHASAs and the State, the MHASAs were required to develop written criteria for determining whether the need for mental health services for a person with co-occurring mental illness and developmental disabilities is a result of the individual's mental illness, or a result of the individual's developmental disability. The criteria developed are then to be approved by HCPF.

Some of the MHASAs indicated they deal with each individual situation, with HCBS-DD clients as it arises, and have not developed any criteria. HCPF has not approved or received any criteria from the MHASAs regarding this contract requirement.

Without established written criteria there is a lack of accountability on either program and leaves the grievance process for consumers, vulnerable to no decisions being made.

It should be noted that there are some written agreements between the MHASAs and CCBs. These agreements were developed without State oversight and generally refer to both parties acting cooperatively with no further guidance. These agreements do not assure that mental health services would be provided locally and in accordance with the person's needs, if at all.

Statute/Regulation/Waiver Site: On page 8, Section II (D) (2) of the mental health managed care contract it states; "The Contractor shall develop written criteria for determining whether the need for mental health services for a person with co-occurring mental illness and developmental disabilities is a result of the individual's mental illness, or a result of the individuals developmental disability. The criteria must be approved by the Department."

Requirement:

HCPF must work with the MHASAs, CCBs and other parties as necessary to develop a solution to this issue. Since there is a contract requirement for criteria to be developed, this must be done, or the contract amended. The State will give a progress report to the CMS RO on this issue by March 1, 2005.

State Response: Agree. The Department is currently working with the BHOs and other agencies as necessary to develop a solution. The Department will provide a progress report to CMS by March 1, 2005.

Federal Response: Look forward to a progress report in March.

Finding 7

The information material on the Grievance and Appeal processes are not compliant with Federal regulations. After review of the Grievance and Appeal information provided to Mental Health Program enrollees the following errors were found in the MHASAs materials:

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- Timelines for filing appeals and State Fair Hearing were incorrect,
- Not all of the information on the process was being provided, and
- The information was not provided in an easily understood format.

Statute/Regulation/Waiver Site: 42 CFR 438.10(g)(1)- This regulation outlines the Grievance, appeal and fair hearing procedures and timeframes that are to be given to enrollees in a State developed or State approved description. In addition, <u>all the items</u> <u>listed in 42 CFR 438.400 through 438.424 and 438 (g) (1), must be included in the information given to enrollees.</u>

Requirement: HCPF is to review the information provided to consumers on the Grievance and Appeal process by each MHASA to make sure it meets contract and regulation requirements. Following HCPF's' review of each MHASAs information material, a report to CMS RO outlining the findings, corrective action plan and a timeline for the MHASAs to correct their information must be completed by March 15, 2005.

State Response: Agree. The Department will review the information provided to consumers on the Grievance and Appeal process by each MHASA/BHO to make sure it meets contract and regulation requirements. A report will be submitted to CMS RO on the findings and corrective action plan and timeline for the MHASAs/BHOs to correct their information by March 15, 2005.

Federal Response: Look forward to the plan and timeline in March.

General Recommendations

Recommendation #1:

Consumers complained that the amount of paperwork required at "Intake", before a provider could be seen, was excessive and intimidating. CMS reviewed a complete "intake packet" and found that some of the documents were HIPAA requirements, and many were not required documents.

CMS recommends that HCPF review the "intake packets" and work with the MHASAs to lessen the burden and process for a consumer to initially get to see a provider. This should be monitored by the State through the State access standards. Consumers expressed that the extensive paperwork requirements have been a deterrent to access to care.

State Response: Agree. The Department will work with the BHOs to address the issues raised regarding the length of the intake packets.

Federal Response: Look forward to how the intake packets may be addressed.

Recommendation #2:

During open discussions with consumers receiving mental health services, they expressed apprehension and fear over the changes in the program that have occurred since the State budget cuts in FY03. They also expressed concern over the transition from DHS to HCPF, and felt like some of the apprehension was caused by a lack of information being provided to consumers throughout the transition and budget cuts.

After the "Budget Cuts" they felt like services had been cut back and were afraid they would loose many more services.

In addition, several consumers, parents of children receiving services and the Executive Director of the Colorado Cross-Disability Coalition (CCDC) relayed to CMS the following concerns:

- 1. Consumers felt there was some "retaliation" by the MHASAs to consumers who became actively involved as advocates
- 2. The absence of consumers on MHASA boards and committees, and
- 3. Long wait times for Urgent and Emergent provider visits.

The State should include in their monitoring plan an evaluation of the services provided to consumers and their appointment times for urgent and emergent services. HCPF is required to make sure that the services being provided are appropriate for the diagnosis, and within the access standards set by the State.

CMS strongly recommends that HCPF require the MHASAs to maintain an active number of consumers on the MHASAs' boards, councils and committees. CMS feels it is important to maintain consumer involvement and input into the program.

State Response: Agree. The Department will evaluate the provision of services and service delivery through reports, site reviews and regional stakeholder meetings.

The Department requires BHOs to provide consumers and families a voice within the policy and decision-making groups of the Contractor's organization, through meaningful representation on groups and the formation of advisory councils. The Department will evaluate this in annual site reviews.

Federal Response: Look forward to reviewing the State's annual site reviews.

Outstanding Issues still to be addressed

Residential Treatment Center (RTC) Issues:

An RTC is a non-hospital based child/adolescent facility licensed by the State of Colorado to provide 24-hour intensive psychiatric care in a residential setting. In the FFS system HCPF pays an RTC a monthly per diem to provide services for children placed in an RTC by the Department of Human Services or Youth Corrections. The MHASAs are only responsible for emergency mental health services, and inpatient psychiatric hospital stays for Medicaid children in an RTC.

While on-site at the MHASAs charts were reviewed of Medicaid children the MHASA had placed in an RTC, and contracts between the MHASA and RTCs. It was determined that the MHASAs also provide a full array of mental health services to children in an RTC. As a result, CMS intends to combine efforts of a FFS audit of RTCs and a review of the MHASAs RTC services in the near future.

Alternatives to Inpatient Hospitalization

During the last few months of SFY03 the Department of Human Services began an initiative titled "Alternatives to Inpatient Hospitalization." The MHASAs in response to the initiative were to develop various strategies to accommodate the release of inpatients from the mental health institutes. Some of the proposed strategies included; modifying and increasing the intensity of Acute Treatment Units, implementing Crisis Stabilization Services and Units, increase personnel (e.g. case managers, clinicians, consumers, medical doctors, program managers, nursing services, support staff), develop a residential facility that functions as a short-term therapeutic alternative to Institutes of Mental Disease (IMDs), implementation of additional wrap-around services, expand the capacity of intensive community based services and increase intensive case management and emergency services coverage.

CMS reviewed various charts of the inpatients released from the IMDs since the beginning of the initiative. The review revealed that the individuals had received none or very few of the proposed additional services.

As a result, CMS will do a focused review in 2005 of the "Alternatives to Inpatient Hospitalization" initiative to evaluate the appropriateness of the federal funding in this program.

<u>Contracts between Counties, MHASAs, State, Child Protection Agencies and other subcontracts</u>

During the on-site review to the MHASAs, CMS received a variety of contracts the MHASAs had with CPAs, Counties, RTCs and other subcontractors. CMS will continue to review and research these contracts.

Exemplary Practices of the State

In the spring of 2004 when CMS conducted a review of the Medicaid mental health program HCPF and the Department of Human Services (DHS) were transitioning the program from one Department to another. HCPF was granted full administrative and operating authority by the Colorado State Legislature in April 2004. Prior to this time, The Department of Human Services (DHS) had been operating and administering the mental health program through an MOU for approximately eleven years.

Since most of the HCPF staff were new to the Mental Health Program, they depended upon DHS staff to respond to CMS. Staffs from both agencies were very professional and cooperative throughout the review regardless of the confusion due to the transition.

It should be noted that both DHS and HCPF staff were very accommodating and cooperative in providing CMS with requested documents, setting up interviews internally and with the MHASAs. In particular, CMS would like to thank Antoinette Taranto, the Project Coordinator with HCPF, for her assistance, professionalism and hard work displayed throughout the review process.

During interviews with consumers, their families and advocates there was varying degree of concerns expressed by consumers with the mental health program, however, the consumer's greatest compliment to the program was that the "Optional Services" had in many cases prevented high emotional and financial costs of being institutionalized. They expressed concern that without this program they would not be able to function in the community.

Consumers believed that the clubhouses, peer support/counseling, and "Warm Lines" were examples of the "Optional Services" that were needed and expressed a request that these services be continued.

Overall it is apparent that the Medicaid mental health program has improved the quality of life for many Medicaid consumers.